

Citizens Health Care Working Group

Listening Sessions, Mississippi Rural Health

**Sponsored/organized by the
Mississippi State University Extension Service**

Summary Report

**Citizens Health Care Working Group
Listening Sessions
Rural Mississippi**

Introduction

Eleven listening sessions were held in rural towns in Mississippi between March 21, 2006 and April 20, 2006. Of the 138 session participants, 102 were female (73.9 percent) and 36 were male (26.1 percent). Only four participants were under 25 years of age (2.8 percent) while 29 (21.0 percent) were between the 25 and 44 years old, 81 (58.7 percent) were between 45 and 64 years of age, and 26 participants (18.8 percent) were 65 years of age or older. Of the participants who indicated their race, 64 (46.7 percent) were Black or African American and 73 (53.3 percent) were white. Only one person indicated Hispanic ethnicity.

Educational levels among the participants were highly varied. Five participants (3.6 percent) indicated that their highest level of educational attainment was elementary school, 15 (10.9 percent) indicated some high school, and 15 (10.9 percent) indicated that they were high school graduates or had obtained a GED certificate. Of the remaining participants, nine (6.5 percent) indicated that they had attended college but did not have a degree, six (4.3 percent) held an Associate's degree, 27 (19.6 percent) held a Bachelor's degree as their highest level of achievement, and 61 participants (44.2 percent) held graduate or professional degrees.

Regarding the participants' primary source of health insurance, 82 (59.4 percent) had employer-based coverage, 17 (12.3 percent) had self-purchased coverage (although an additional four participants indicated that they utilized self-purchased policies as a supplement to Medicare), 23 participants (16.7 percent) had Medicare as their primary means of coverage, six (4.3 percent) utilized Medicaid, four (2.9 percent) had Veteran's coverage, eight (5.8 percent) had coverage from a source not mentioned, and 13 (9.4 percent) did not have any type of health care coverage. One person was not sure of their insurance coverage status.

Seventy-two participants (52.2 percent) indicated that they had full-time employment and 17 (12.3 percent) said they were self-employed. Twenty-nine (21.0 percent) worked part-time while 15 participants (10.9 percent) were retired. Five participants (3.6 percent) indicated that they were either not employed or were currently looking for work (of these, one person listed her work status as "Homemaker").

State of the U.S. Health Care Sector

Forty-eight respondents (34.8 percent) indicated that they believed the U.S. health care system was in a state of crisis while an additional 59.9 percent (82 respondents) said that the system had major problems. Of the other seven respondents, three believed that the U.S. health care system had minor problems, one believed that the system had no problems, and two respondents had no opinion.

With regard to the purpose of health care coverage, 62 respondents (45.3 percent) felt that the primary purpose of coverage was to assist in paying for everyday medical expenses while 75 respondents (54.7 percent) felt that it was to cover high (catastrophic) medical costs.

Values

While a tremendous number of beliefs in the inherent values that a health care system should have were expressed, the majority of these beliefs could be grouped into five major categories. Values regarding ***affordability*** and ***quality of care*** ranked highest in terms of the rating system used (9.3 for each on a scale of 10) and each of these garnered a significant number of responses (198 and 178, respectively). Third on the rating scale was ***accessibility*** (8.9). However, the total number of responses related to this issue far outdistanced other concepts mentioned (356). One hundred seventy-eight responses for the concept of ***personal responsibility*** were recorded (this issue received an overall 8.7 rating) while ***choice of care*** rounded out the list (136 responses with a 8.5 rating).

However, a simple summary of the votes cast on these issues does not due them justice. Specific responses rated by the sessions' participants included the following:

Accessibility

- Locally available doctors and providers willing to treat all patients all the time;
- Available without regard to income level;
- Doctors should accept whatever insurance a patient has;
- Portability (Medicaid is not portable from state to state);
- Timely service;
- Right number of doctors for the population; and
- Differences in urban versus rural geographies.

Affordability

- Cost effectiveness;
- Fair pricing;
- No disparity of costs between insured and uninsured;
- No insurance should not mean no health care; and
- Prescription drugs should be accessible at a fair price.

Quality of Care

- Competence of providers;
- Good emergency care;
- A minimum standard of care;
- Safety;
- Evidence-based medicine; and
- Uniform standards for all.

Personal Responsibility

- Education;
- Responsibility; and
- Utilizing preventive care services.

Consumer Choice

- Choice of providers, facilities, and prescription drugs (generic versus non-generic);

- Plan flexibility; and
- Patient-driven decision processes.

With regard to the question “Should it be public policy that all Americans have affordable health care coverage?”, 109 respondents (77.9 percent) agreed that all Americans should have affordable coverage.

Benefits

When the respondents were asked to choose between providing health care coverage based on who you are (the current status of the system) or providing a basic level of services for everyone, 28 (20.4 percent) chose to keep the system the way it is while 109 respondents (79.6 percent) chose the option of providing a basic level of services for everyone.

Respondents gave a wide variety of responses regarding the additions to the sample basic health care package offered. However, as with a previous question, the higher scoring responses could be condensed into a manageable number of groups (5). The highest rated of these groups included services associated with catastrophic care. Ninety-four respondents gave this issue a rating of 9.0 on a scale of 10. Coverage for durable medical equipment had 81 responses and received an 8.5 rating.

As with the previous question, the issue groups that garnered the largest number of responses did not receive the highest ratings. Coverage for home care, long-term care, and hospice services received an 8.1 rating and 265 responses. The largest number of responses were reserved for coverage of dental, vision, and hearing services (313) and this issue group received a rating of 8.0. Rounding out this group was coverage for education and prevention services (141 responses for a rating of 7.6).

Respondents were much less apt to drop services from the sample basic care package. The three main categories that respondents leaned toward dropping were physician and provider home and office visits (32 responses for a score of 7.4), chiropractic care (110 responses for a score of 6.1), and substance abuse coverage (49 responses for a score of 5.3). Other suggestions for items to be dropped included limited dental care, limited mental health care, limited prescription drug benefits, and routine physicals. However, these items were rated relatively low by the respondents (a low rating indicated a desire to keep the service in the basic health care package) and garnered a relatively few number of responses.

Respondents rated the input of the five stakeholders to a basic benefit package as follows: consumers should have the largest level of input (8.7), followed by medical professionals (7.2), employers (6.6), the government (5.1), and insurance companies (4.5).

Getting Health Care

The vast majority of the responses regarding factors in getting health care focused on **accessibility** issues (425 responses for an overall rating of 8.9). **Affordability** issues had the highest rating (9.4) and the second largest number of responses (176). These issues were

followed by *quality of care* concerns (a rating of 9.2 with 154 responses) and *consumer choice* issues (118 responses with a rating of 8.7).

Since there were a large number of issues raised within these four groups, a representative list of issues for each group is provided:

Accessibility

- Access to health care providers, services, and specialty care;
- Timely care;
- Distance and transportation;
- Continuity of care and medical records;
- Portability;
- Adequate number of providers; and
- Elimination of red tape.

Affordability

- Deductibles and co-pays;
- Getting what you think you're paying for (having insurance doesn't necessarily mean coverage); and
- Pricing visibility

Quality of Care

- Clean facilities;
- Consistency of care;
- Provider competency; and
- Quality of insurance benefits.

Consumer Choice

- Choice of coverage, services, and preferences;
- Choice of providers; and
- Network versus non-network coverage.

Financing

With regard to the initial questions on financing health care listed at the beginning of Deliberation 3, 98 respondents (73.7 percent) indicated that everyone who can afford to do so should be enrolled in basic health care coverage. Seventy-six respondents (57.6 percent) indicated that some people should be responsible for paying more than others. Criteria that should be utilized in determining who pays more included family size (54 respondents, 40.0 percent), health behaviors (69 respondents, 51.1 percent), and income (67 respondents, 49.6 percent).

The majority of the respondents (105 respondents, 77.8 percent) felt that public policy should continue to use tax rules to encourage employer-based health insurance and 115 respondents (85.2 percent) felt that government resources should continue to be used to continue current programs that provide health care coverage to some people who otherwise could not afford it.

In responding to the question about what individuals and families should be responsible for in paying for health care coverage, responses fell into three main categories. The highest number of responses (353) was centered on individual responsibilities to adopt a health lifestyle and to take advantage of educational opportunities to achieve that lifestyle. This issue group received a rating of 8.2. Issues about an individual's responsibilities to contribute money or some other type of service (community service or working off medical bills) received a 7.5 rating with 225 responses and issues surrounding the individual's responsibilities to budget for their health care and follow medical advice as prescribed received 148 responses and an 8.4 rating.

While there were likewise many suggestions on how the growth of health care system costs could be slowed, these fell into four major categories. Individual and civic responsibilities not only garnered the highest number of responses (442), but also received the highest rating (8.6). Suggestions to change or reform the system received 402 responses and an 8.0 rating; price controls on the system had the highest rating (8.5), but had the fewest number of respondents (147); and governmental mandates received 178 responses and an overall rating of 7.8. Representative lists of responses for each of these issue groups area shown below:

Individual Responsibilities

- Annual checkups;
- Don't reward kids with junk food;
- Parents taking greater responsibility for rearing children;
- Education about healthy behaviors;
- Eliminate excessive and unnecessary provider visits;
- Employer wellness programs;
- Incentives for healthy behavior; and
- Physical education in the schools.

System Reform

- Make preventive care services as sexy as walking around the mall with a cell phone;
- Abolish HMOs;
- Adopt best practices for treatment and continually evaluate those practices;
- Decrease litigious behavior;
- Eliminate practice of defensive medicine;
- Improve "shared" electronic medical records;
- Increase use of generic drugs; and
- Reduce bureaucracy and complexity of health care system.

Price Controls

- Cap drug costs;
- Cap payment reimbursements;
- Cap charges for services; and
- Caps on end-of-life care spending.

Governmental Mandates

- Eliminate pharmaceutical marketing;
- Form national associations for different industries to make insurance accessible and affordable;
- Limit legal class action advertising;
- Malpractice litigation caps/tort reform;
- Limit medical advertising to the public;
- Tax deductions for individual insurance premiums;
- Use of sin taxes (behavior-based) for direct health care; and
- Target more Medicaid funds for health care.

Trade-Offs and Options

With regard to additional amounts that participants would be willing to pay to support efforts that would result in every American having access to affordable, quality health care, 29.3 percent of the respondents indicated that they would not be willing to provide any funding for this effort, 14.7 percent said that they would willingly give between \$1 and \$100 annually, 12.1 percent said they would be willing to spend between \$100 and \$299 annually, 17.2 percent said they would provide between \$300 and \$999 annually, and 10.3 percent said that they would give \$1,000 or more to this cause. There were, however, a relatively large number of people (16.4 percent) that said that they did not know how much extra they would be willing to pay to achieve this goal.

In examining the list of spending priorities, respondents statewide indicated that each of the options presented should be considered, although some were definitely more desirable than others. The following table lists each question (in descending order according to the rating that the question received) with the overall statewide rating:

Rating	Spending Priority
9.2	Investing in public health programs to prevent disease, promote healthy lifestyles, and protect the public in the event of epidemics or disasters
8.8	Guaranteeing that all Americans get health care when they need it, through public “safety net” programs (if they can not afford it)
8.7	Guaranteeing that there are enough health care providers, especially in areas such as inner cities and rural areas
8.6	Guaranteeing that all Americans have health insurance
8.6	Preserving Medicare and Medicaid
8.5	Funding biomedical and technological research that can lead to advancements in the treatment and prevention of disease
8.0	Funding the development of computerized health information to improve the quality and efficiency of health care
7.9	Funding programs that help eliminate problems in access to or quality of care for minorities

In rating the trade-offs provided in the ballot, respondents much more interested in the expansion of current programs and services than they were in initiating new programs or in creating radical departures from existing programs. Top-rated trade-offs included the expansion of current tax incentives available to employers for employee health insurance provision, expansion of

neighborhood clinics, expansion of state government programs, and opening enrollment in national federal programs. Among the least desirable options involved creating a national health insurance program or allowing the free market to define benefits and set prices. The following table lists these options and their ratings in descending order.

Rating	Trade-Off
8.3	Expand current tax incentives available to employers and their employees to encourage employers to offer insurance to more workers and families
8.2	Expand neighborhood health clinics
7.7	Expand state government programs for low-income people, such as Medicaid and the State Children's Health Insurance Program, to provide coverage for more people without health insurance
7.5	Open up enrollment in national federal programs like Medicare or the federal employees' health benefit program
7.3	Require that all Americans enroll in basic health care coverage, either private or public
7.2	Offer uninsured Americans income tax deductions, credits, or other financial assistance to help them purchase private health insurance on their own
7.2	Increase flexibility afforded states in how they use federal funds for state programs -- such as Medicaid and S-CHIP -- to maximize coverage
7.0	Require businesses to offer health insurance to their employees
6.7	Create a national health insurance program, financed by taxpayers, in which all Americans would get their insurance
4.8	Rely on free market competition among doctors, hospitals, other health care providers, and insurance companies rather than having government define benefits and set prices

Closing Comments

It is obvious that the residents of Mississippi have a wide variety of ideas concerning our health care system. While this report provides an overall view of the responses from Mississippi's citizens, the individual site reports should be examined closely as well. There are distinct differences between the geographies of the state. These are due in part to culture, but also are due to experiences (e.g., Hurricane Katrina). It should also be remembered that the comments and responses contained in the reports submitted by the Mississippi State University Extension contain the views of rural peoples and may be very different than those of their urban counterparts. In closing, one thought was expressed in many of the sessions: There are vast differences in urban and rural geographies overall and the health care systems in many rural areas magnify this difference.